Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TASB RISK MANAGEMENT FUND

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-11-3057-01

MFDR Date Received
May 10, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Upon further review we have note that the correct pre authorization number has been located in the appropriate box on the cms-1500 since it's initial faxing on 8/11/10. Please reprocess and pay accordingly."

Amount in Dispute: $307.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No surgical procedure was performed. The date of injury was August 4, 2006 and the 2 week rule after the date of injury has past. May 12, 2010 was after the two week period, so pre-authorization is required by Workers' Compensation rule 134.600 for services rendered May 12, 2010. Preauthorization # ARR08102009001 that was submitted with the DMR was approved for 4 sessions from date of service 8/11/09 through 9/11/09. The date of service that is submitted for the MDR is past the dates that were preauthorized. Physical therapy was first rendered on March 31, 2010 and continued through May 12, 2010 was denied because no preauthorization request was submitted for the dates of services."

Response Submitted by: TASB RISK MANAGEMENT FUND

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2010 and June 28, 2010	97110, 97112, 97150 and 99213	$307.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the preauthorization, concurrent review and voluntary certification of healthcare guidelines.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 27, 2010
   - 197 – Payment denied/reduced for absence of precertification/authorization. Preauthorization required but no requested per Rule 134.600.
   - W1 – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated April 15, 2011
   - 197 – Payment denied/reduced for absence of precertification/authorization. Preauthorization required but no requested per Rule 134.600.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly. 04/14/11-Maintain original denial as no preauthorization for these services on file. Applies to all lines.
   - W1 – Workers Compensation State Fee Schedule Adjustment. Original payment decision is being maintained. Upon review it was determined that this claim was processed properly. 04-14-11 – Maintain original audit.

Issues

1. Did the requestor obtain preauthorization for the physical therapy services rendered on May 12, 2010?
2. Did the requestor submit documentation to support the billing of CPT code 99213 rendered on June 28, 2010?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes... (5) physical and occupational therapy services..."
   - Review of the submitted documentation finds that preauthorization was not obtained for CPT codes 97110, 97112, 97150 and 97140 rendered on May 12, 2010. As a result, reimbursement cannot be recommended for the physical therapy services.
2. Per 28 Texas Administrative Code §133.307 "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute..."
   - The insurance carrier's position summary did not provide an explanation for CPT code 99213 rendered on June 28, 2010. Review of the EOBs submitted by the requestor indicates that payment was issued in the amount of $99.84 for CPT code 99213 under check # 5338454 issued on September 14, 2010. As a result no further reimbursement is recommended for CPT code 99213.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.